STATE OF MONTANA
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
CHILD CARE LICENSING PROGRAM

STATEMENT OF HEALTH FORM

NAME: (Please Print) _____ Phone Number _____

Address _____ City, State, Zip _____

Social Security Number _____ Birth Date _____

Facility Name _____

I am: [ ] A Day Care Provider [ ] A Care Giver [ ] A Spouse [ ] Other Adult Living in the Home

Applicants and providers must meet certain personal health requirements. As the agency responsible for Child Care registration/licensing, the Department of Public Health and Human Services (DPHHS) must ensure that the health of each provider is adequate to meet the demands of the care being provided.

Please answer the following questions by entering an "X" in the appropriate box for each question.

The Child Care Licensing worker completing the licensure study and the Child Care Licensing Program Manager who issues the license will review this form. In some cases, the answer "yes" to a question may require an evaluation or a statement from your physician or other appropriate professional to support your responses. The answer "yes" does not mean you will automatically be denied a registration/license. Your explanation or, if necessary, your physician's or other appropriate professional's statement will be taken into consideration. The purpose of the questions is to help decide if you have health problems that may affect your ability to safely provide care. The Child Care Worker will discuss with you the type of additional information needed. If an evaluation or statement is needed, the specialist will assist you in completing the authorization form for your physician or other appropriate professional. Any evaluations, tests, or visits to your physician or other professional(s) must be paid by you.

[ ] Yes [ ] No During the past 3 years, have you had any disabling chronic conditions, or physical, mental, or emotional illness requiring care from a physician, psychologist, or other professional?

- If, "Yes," please describe. Include a description of any vision or hearing problem and any limitation on mobility. Include treatment and current status. (You may use additional paper if needed.)

[ ] Yes [ ] No Do you suffer from any physical or mental health limitations which might affect your ability to provide day care?

- If "Yes," Please explain. (You may use additional paper if needed.)

[ ] Yes [ ] No Are you currently diagnosed, receiving therapy or medication for a mental health problem which might affect your ability to provide care?

- If "Yes," Please Explain. (There is additional room on the next page.)

[ ] Yes [ ] No Have you received counseling or treatment related to chemical dependency on drugs or alcohol within the past three years?

- If "Yes," Please Explain. (You may use additional paper if needed.)

[ ] Yes [ ] No Have you ever been addicted to drugs and/or alcohol or been treated for drugs and/or alcohol abuse within the past three years?

- If "Yes," Please Explain. (You may use additional paper if needed.)

Additional Comments:

PLEASE READ, THEN SIGN AND DATE:

I certify that I have reviewed the foregoing information supplied by me and that it is true, accurate and complete to the best of my knowledge. I further certify that I fully understand that any misstatement on my part in completing this health statement is grounds for denying my application or for revoking my registration/license should one have been issued to me on the basis of the statements I have made herein. I understand this information is confidential and is to be used only by the Department of Public Health and Human Services for the administration of the child care licensure program. I hereby consent to the use of this information for such purposes.

SIGNATURE: _____ **DATE**:_____